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ABSTRACT

Vocational rehabilitation (VR) counselors in states where American Indians reside in large numbers were surveyed to determine the proportion of American Indian clients with alcohol or substance abuse problems in the counselors' caseloads and the kinds of specializes services provided to the clients A total of 124 VR counselors from 14 states responded to the survey. Twenty-seven of the respondents were employed in tribally operated VR projects in nine states. Thirty-nine respondents were American Indians themselves. Results are reported for the following areas: relationships with clients, minimum period of sobriety before implementing services, training background and needs, treatment modalities, elements of treatment, and aftercare. The survey found that Native American traditional healing was the most highly rated treatment model. About one-third of responding counselors wanted more training, with workshops selected as the preferred vehicle. A need for certain VR support services, such as maintenance services, was also found. Recommendations address design of training workshops, exemplary treatment programs, and alternatives to abstinence requirements before implementing VR services. A bibliography of approximately 200 items is attached along with a sample cover letter to respondents and a list of recommended programs. (Contains 36 references and 5 tables.) (DB)

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The Vocational Rehabilitation Of American Indians Who Have Alcohol And Other Substance Abuse Disorders

Preliminary Report
December 1993

Robert M. Schacht, Ph.D.
Lee Gaseoma, M.A.

American Indian Rehabilitation Research and Training Center
Institute for Human Development
Arizona University Affiliated Program
Northern Arizona University
PO Box 5630
Flagstaff, Arizona 86011-5630
(602) 523-4791

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Abstract

The ratio of American Indians with alcohol or substance abuse problems accepted into vocational rehabilitation services caseloads has been consistently higher than that of the general population. The purpose of this study was to determine the need for specialized rehabilitation services to American Indians with substance abuse or alcohol problems. Vocational rehabilitation counselors in states where American Indians reside in large numbers were surveyed to determine the proportion of American Indian clients with alcohol or substance abuse problems on their caseloads and the kinds of specialized services provided to them. A total of 124 VR counselors from 14 different states responded to the survey. Twenty-seven of these respondents were employed in tribally operated VR projects in nine states. Also, there were 39 American Indian VR counselors among the respondents.

Introduction

Alcohol and substance abuse are often viewed as one of the most, if not the most, widespread and severe health problems among American Indians. These health problems contribute significantly to and greatly exacerbate almost every other of their most serious problems (Apodaca, 1984). As a group, American Indians also have a higher alcohol consumption than other ethnic groups or subgroups in the United States, according to Weisner, Weibel-Orlando, and Long (1984). The extent of these problems has been reported in detail by Levy and Kunitz (1974), Burns (1974), Vanderwagen, Mason, and Owan (1986), and many others.

A major source of data on this problem is the Indian Health Service. Andre (1979) reported that approximately 70% of all IHS treatment services are for alcohol related conditions (Vanderwagon, Mason & Owan, 1986; Hodgkinson, 1992). American Indians of all ages have a higher death rate than the U.S. general population, and alcoholism is a major factor contributing to deaths in all age categories (Morgan, Hodge & Weinmannn, 1987). This is especially true for the young adults (age 15-34), for whom the death rate due to alcoholism (i.e., alcohol dependence, alcohol psychoses, and chronic liver disease) is more than 11 times that for the general population. Similar data from IHS inpatient hospitalization summaries indicates that Alcohol Dependence or Alcohol Psychosis and Alcoholic Liver Damage diagnoses are more than three times as common in IHS hospitals as in similar short-stay hospitals used by the U.S. general population, accounting for more than 4% of primary IHS diagnoses. Another study showed that alcohol-related diagnoses (ARD) accounted for an overall estimated per annum rate of 13.7% of the adult inpatient days at 43 IHS facilities. IHS discharge rates for ARD over the period of study were three times greater than reported ARD discharge rates for the U.S. civilian population (Hisnanick & Erickson, 1993).

There may also be differences in alcohol metabolism between American Indians and other races, but a recent review of the literature does not support this hypothesis (May, 1989). Recent work on the genetics of alcohol metabolism, using different methodologies (e.g., Bower, 1991), have not yet been able to demonstrate any racial differences and are concentrating instead on metabolic variations controlled by specific genes in alcoholics vs. nonalcoholics without regard to race or ethnic group. This work may eventually prove relevant, but the genetic link for alcoholism remains controversial.

However, in order to avoid the "drunken Indian" stereotype (Westermeyer, 1974; May, 1989), it is crucial to understand that American Indians are not a homogeneous group and that there are differences both within and between tribes in rates of alcoholism and substance abuse (Stratton, Zeiner & Paredes, 1978; Young, 1988). Even if there are genetic factors involved, these may vary in frequency within and between groups as well as between Indians and non-Indians. For example, there is considerable variation between IHS areas in the frequency of Alcohol Dependence, Alcohol Psychosis, and Alcoholic Liver Damage diagnoses, from above 6% in the Aberdeen and Albuquerque areas to less than 2% in Oklahoma (Morgan, Hodge & Weinmannn, 1987). Wiesner, Weibel-Orlando, and Long (1984) provided evidence that there is an association between lifelong drinking styles and tribal origin. However, they find that the reasons for this association are complex and that the best predictors of drinking level are sex, age, the models of drinking behavior provided by the family of origin, and psychological stress. They point out that

> Given the high rates of alcohol consumption and related sequelae in Indians as a group, it is often overlooked that substantial numbers of them do not drink at all or drink in moderation. How do these Indians differ from the heavier drinkers? We are not asking why one tribe drinks more than another or why Indians as a group drink more than non-Indians but rather what characterizes intratribal differences in drinking levels.

However, it is also true that a number of tribes have given special recognition to some of these problems among their members. For example, alcoholism has been identified by the Health and Human Services Committee of the Navajo Tribal Council as "the leading health problem" among Navajos (Morgan, Hodge & Weinmannn, 1987, 80). It has also been cited by the Alaska Native Health Board as "the most serious health hazard" facing Natives and non-Natives in rural Alaska (p.91).

It is also clear that this is a problem in rehabilitation in that the ratio of American Indians accepted into Rehabilitation Services Administration caseloads for alcohol abusee during 1980-1982 was almost 19% and was 3.34 times higher than for U.S. general population clients (Morgan, Hodge & Weinmannn, 1987); this does not include cases where alcoholism is considered a contributing

(but not the primary) disability. In a multistate survey of 332 vocational rehabilitation counselors, Martin, Frank, Minkler, and Johnson (1988) found that one third of the counselors responded that chemical dependency among their clients was "seldom" to "almost never" manageable during the vocational rehabilitation process. The counselors were also asked to rank which agency personnel were the most important with whom to work closely in order to provide effective services to American Indian clients. From a list of 22 service providers, the category of chemical dependency counselors was ranked first, as the most important provider (summarized in Marshall, Martin & Johnson, 1990). The results of this survey indicate the importance of this problem in rehabilitation and point to a need for a follow-up survey to provide more information about whether available rehabilitation services are adequate to meet the needs of these clients (see also R. Young, 1986).

As Morgan, Hodge, and Weinmann (1987) pointed out, these results have a variety of policy implications. An agreement between IHS and BIA has been signed to begin a coordinated effort to combat alcohol and substance abuse among American Indians and Alaska natives. This creates the potential for jurisdictional problems in coordinating rehabilitation services. In vocational rehabilitation, a counselor may refer a client for alcohol and substance abuse treatment, but the extent to which direct services for this problem can be provided is not clear. A variety of referral opportunities are available, but availability may vary considerably from one city or town to another.

Literature Review

During the course of this project, a literature review catalogued more than 200 references of all kinds, more than 100 of which have appeared during the past 10 years. This catalogue is reproduced as appendix A. Sources up to 1986, which have been reviewed by Young (1986) are not included in appendix A. While it is not our purpose here to systematically review these resources, some of the work is summarized below.

Toxicology Screening. The results of rapid toxicology screening of paired blood and urine samples were compared with results of a comprehensive screening method (Bailey, 1990). The study sample included 936 patients admitted to a university trauma center during the year 1988, who underwent limited screening and who were compared to 381 patients admitted in 1985 who underwent comprehensive screening. The study results revealed that in the 1988

sample, 65% were positive for one or more drugs. Positive screens were found in 80% of American Indians, which was higher than for Blacks, Hispanics, and Asians/Pacific Islanders. It was concluded that rapid toxicology screening was a cost-effective and rapid method for obtaining useful information.

The MMPI. The Minnesota Multiphasic Personality Inventory (MMPI) is one of the most widely used personality tests. There are five MMPI alcoholism scales, and their general validity has been the subject of a vigorous debate (Hays & Stacy, 1983; Holmes et al., 1984). Its validity among Native Americans has been challenged by Pollack and Shore (1980) and by Hoffman, et al. (1985). Pollack and Shore's study concluded that there was a significant cultural influence on the results of the MMPI in a population of 142 American Indian patients from Northwest Coast tribes. They noted that it appears that cultural influence overrides individual pathology and personality difference in influencing the pattern of the MMPI. However, rather than recommending American Indian cultural norms for the MMPI, they suggest the need for cultural research that identifies culturally appropriate instruments for this purpose. A subsequent analysis of MMPI performance of 65 Rosebud Sioux by Hoffman, et al. (1985) supported their hypothesis that acculturation influences the MMPI performance of Native Americans. Use of the MMPI and the MacAndrew Scale of the MMPI with American Indian adolescents in California has been studied by Heuberger (1989).

The CAGE test. Recent reviews of widely used screening tests for alcoholism showed that CAGE (Ewing, 1984), while it did not perform well enough to serve as a screening tool for problem drinking within the college student population (Heck & Lichtenberg, 1990), proved to be a useful screening device for identifying those with mild to moderate substance abuse problems (Lairson, et al., 1992). Another study found that the CAGE score was the best predictor of covert alcoholism, with a *sensitivity* (number of true positive results divided by the sum of the true positives and false negatives) of 76% and a *specificity* (number of true negatives divided by the sum of the true negatives and false positives) of 94%. The overall predictive power was calculated at 87% (Beresford, Blow, Hill, Singer, & Lucey, 1990). The CAGE Screening Test for Alcoholism contains only four questions, as follows (Mendelson & Mello, 1992, p. 469):

1. Have you ever felt the need to Cut down on drinking?
2. Have you ever felt Annoyed by criticism of your drinking?
3. Have you ever felt Guilty about your drinking?
4. Have you ever taken a morning Eye opener?

The CAGE test takes its name from the initial letters of key words in each question, indicated here by underlined bold capitals. The predictive value of the CAGE in screening for alcoholism or alcohol abuse increases with the number of positive responses: 62% for one positive answer, 82% for two, 99% for three, and 100% for four (Mayfield, et al., 1974, cited in Mendelson & Mello, 1992, p. 469). Unfortunately, however, this literature review did not identify any validation of this screening test with American Indian/Alaskan Native populations.

The MAST. The Michigan Alcoholism Screening Test (MAST) is another popular screening test. It has several short and brief forms with 9-13 questions and longer forms (24-35 questions). The "short" form has 13 unweighted questions; a score of three or greater is positive for alcoholism. A score of two indicates "possible alcoholism," and lower scores are considered nonalcoholic (Mendelson & Mello, 1992, 470). The original form was developed by Seltzer (1971) in the Midwest and was intended to be a self-reporting screening device for alcohol use. Using the original 25-item questionnaire, Seltzer established that a score of zero to three is associated with normal social drinking, four is borderline, and a score of five or more indicates established alcoholism (summarized in Wolf, 1989, p. 38). However, no special studies on using the MAST on American Indian populations were known until the MAST was used with Alaska Natives in Barrow (Klausner and Foulks, 1982). They found that 72% of the population had a score of five or more. A percentage this high had been achieved in only two prior studies, where the subjects were drunk drivers. When compared to the prior populations, this measure indicated a major skew in the direction of both alcohol and violence. When this data was released to the press in order to "shock the Inupiat into action," the figures lent themselves to "over interpretation" by the press, resulting in a major controversy that may have set back research on alcoholism in rural Alaska "rather substantially" (summarized in Wolf, 1989. pp. 38-39).

Perhaps part of the controversy stemmed from a confusion between a *screening device* and a *diagnostic assessment*: a screening device serves the primary purpose of drawing attention to a *potential* problem requiring a more detailed diagnostic assessment by professionals in order to establish how serious the problem might be. Wolf (1989, p. 38) has continued to use the MAST with Alaskans with a variety of backgrounds, including Natives, but thinks that the test should be "renormed for this population, and viewed in relation to what is known about the physiology of blackout in the Native drinker." The

implications of this controversy are not against the *use* of the MAST but amply demonstrate the problems which can arise from a *misuse* of the MAST.

Indigenous Alcoholism Treatment Strategies. There have been a number of attempts to evaluate treatment strategies for American Indians/Alaska Natives who have alcoholism. Vanderwagen, Mason, and Owan (1986) have outlined the development of Indian treatment and prevention programs (pp. 21-23) and have provided a substantial bibliography (pp. 31-35). They report that treatment programs based on Alcoholics Anonymous began to develop in the middle to late 1950s, alongside Indian spiritual movements with traditional roots such as the Iroquoian longhouse, Indian Shaker, and the Native American Church. These efforts received a major boost with Office of Economic Opportunity funding for outreach and treatment in Indian communities in the late 1960s. This culminated in 1970 with the passage of P.L. 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (42 USC 4582), which created the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Initial NIAAA funding was for demonstration purposes only; as these programs matured, they eventually were transferred to IHS for long-term support.

Young (1986) has reviewed the literature on treatment strategies for Native American alcoholics up to 1986. He observed that in Guyette's (1982) study of an urban population, 76% of the treatment population preferred a combination of Native American healing practices and Western treatment strategies, while 10% preferred exclusively a Native American treatment strategy. Although he found very little information about what constitutes a successful treatment strategy, one important feature of such programs would include a spiritual component the client is responsive to. This includes the AA approach, but the success of that program appears to depend to some extent on how well the AA confessional approach is adapted to specific cultural factors in the client's socialization. The importance of the spiritual component is also emphasized by the Native American psychologist, Eduardo Duran (1990), who observed that "to accomplish a relevant treatment process the traditional way of healing encompasses symbol, myth, and ritual" (p. 82).

In another study, 52 alcoholism treatment programs in the western United States were visited and observed during 1981-1983. In a report on 26 of these programs, located in California and South Dakota, Weibel-Orlando (1989) rated each program on the basis of six characteristics: (a) ethnicity of staff and

personnel, (b) strength of AA affiliation, (c) type of counselor training, (d) treatment and counseling techniques, (e) cultural accommodation, and (f) level of cooperation with tribal healers. Each of these was rated on a five-point scale ranging from Anglo orientation to Indian orientation. On the basis of these program characteristics, she identified five types of treatment models: (a) the Medical Model, (b) the Psychosocial Model, (c) The Assimilative Model, (d) the Culture-Sensitive Model, and (e) the Syncretic Model. These range from most extreme Anglo orientation exemplified by the Medical Model (all Anglo staff; very strong AA orientation; counselors with university degrees who treat alcoholism as a medical disease, making little or no cultural accommodations, involving no cooperation with Indian healers) to a mostly Indian orientation on all six scales. The syncretic approach is exemplified by Duran (1990) who, near the end of a description of his clinical practice with Native American clients who suffer from alcoholism, writes (p. 90):

> I want to stress that the client may also be involved in AA meetings, Christianity, as well as traditional ways of living in order to deal with the alcohol problem. I encourage the client to use all which makes sense to him. The therapy is then tailored to offer him/her the highest level of respect regardless of which therapeutic modality they desire. The therapist must remain centered as much as possible and should be comfortable in dealing within any of these frameworks.

In a discussion of the relative efficacy of treatment modalities, while acknowledging the importance of such information, Weibel-Orlando (1989) laments the lack of useful information, concluding that (p. 136)

> The issue at hand is that no one, whether treatment program director, funding agency administrator, or research and evaluation team member, knows what kind(s) of treatment modality works consistently with American Indian clientele.

The assumption underlying this conclusion is that one model can fit American Indians/Alaska Natives. Funding agencies discourage a consideration of diversity that would allow programs to use several models that could potentially benefit American Indian consumers from a variety of tribal traditions.

Purpose

The purpose of this project was to determine the perceptions of VR counselors who work with American Indians/Alaska Natives about the magnitude of alcoholism and substance abuse as a problem for their American Indian/Alaska Native clients; how seriously they think it affects rehabilitation outcome; and what, if anything, they think VR should do that can be done under current legislative mandates.

Methodology

The basic methodology of this research project will be a survey of VR counselors. The survey was national in scope but focused mainly on areas where American Indian/Alaska Native populations were concentrated.

Before the survey was conducted, however, a comprehensive literature search and resource inventory was initiated. This literature review concentrated on the past ten years, under the assumption that references to earlier sources could be found in the bibliographies of these more recent works.

To develop the survey instrument, an advisory committee was established consisting of four American Indian VR counselors, four program directors, an RSA district program manager, and the superintendent of an American Indian school district who had a background in the treatment of alcoholism. Nine of these were American Indians/Alaska Natives. The authors and the AIRRTC director developed initial drafts of the questionnaire, which was then sent out to advisory board members for review, corrections, and comments.

The resulting questionnaire was then pilot-tested with four VR counselors (three in–state, one out–of–state). After discussion with these counselors, additional changes were made, and the questionnaire was finalized. Meanwhile, administrators of RSA and Section 130 tribal VR programs were being contacted to enlist their support for the survey. If they agreed to participate, they were asked to name a liaison person who would identify appropriate counselors to send the survey to.

With the assistance of the liaisons, about 300 questionnaires were sent out. In most cases, the liaison person identified only those counselors known to have American Indian or Alaska Native clients with alcoholism or substance abuse as a disability; in some cases, however, questionnaires were sent to a wider range of counselors. A cover letter (example, appendix B) asked them to respond if appropriate. Sometimes follow-up calls were made to the liaison person in order

to expedite the responses. Counselors were asked in the questionnaire if we could contact them with any follow-up questions. This proved valuable, as some responses were incomplete or unclear.

Completed questionnaires were entered into a database on an IBM PC using Symantec Corporation's "Q&A" software. The analysis was done using this software.

Results

A total of 124 VR counselors from 14 different states responded to the survey. These included 39 who were American Indians or Alaska Natives, representing about 20 different tribes. Fifty three (53) of the counselors had more than 12 American Indians/Alaska Natives with alcoholism or substance abuse disabilities (primary, secondary, or tertiary) on their case load.

Casework

Respondents were asked to rate aspects of their relationships with clients who have alcoholism/substance abuse problems. Their responses are presented in Table 1, in descending order of importance.

Table 1.

Relationship with Clients

Item	Always	Usually	Some-times	Rarely	Never	Total	Mean
Honesty & directness	81	37	3	1	1	123	1.41
Encourage client to be more responsible, productive and self-reliant	75	44	1	1	2	123	1.46
Being a "sober" model, a "straight" authority figure	72	30	9	7	3	121	1.67
Awareness of information and other services which can be useful to the client	49	64	9		1	123	1.70
Personal warmth and empathy, along with firmness	48	63	8	2	1	122	1.73
An evaluation of the client	53	49	15	1	3	121	1.78
Communicating a reality-based, ordered, disciplined and responsible way of life	50	49	16	4	1	120	1.81
Ability to set limits	39	70	11	1	1	122	1.81
The ability to listen without judging	41	69	9	3	2	124	1.84
Ability to confront potentially destructive thinking or behavior	40	64	17	1	1	123	1.85
Educated and informed compassion & emotional support (without "enabling")	34	70	14		1	119	1.86
Awareness of choices that the client may not see	35	67	18		1	121	1.88
Time & availability	47	48	22	2	3	122	1.90
Interpreting evaluations of others for client	27	51	28	5	9	120	2.32
Family therapy	18	32	33	30	10	123	2.85
Native healing or diagnosis	5	12	23	34	43	117	3.84

Respondents were asked about the minimum amount of time they required that a client be detoxified or abstinent before beginning to implement VR services. Their responses are tabulated in Table 2. About one third (34%) said there was no minimum period. Almost as many (29%) indicated one week to at least two months, and the same number (29%) indicated at least 3 to 6 months. Another 9% indicated that it would depend on various other factors.

Table 2.
Minimum Period of Sobriety Before Implementing Services

Minimum period	N	%
No minimum	40	34%
At least one week	2	2%
At least one month	21	18%
At least two months	10	9%
At least three months	23	20%
At least six months	10	9%
Depends	10	9%
Total	116	

Respondents were then asked what VR services their clients with alcoholism/substance abuse usually received for this disability while a client of their agency, and how these services were funded (Table 3). The services most often received were Counseling and Guidance, and Assessment. Counseling and Guidance was the service most likely to be provided directly; Assessment was the most likely to be purchased; and Assessment and Restoration were the services most likely to be received as a similar benefit. Responses were scored on a three point scale from "Always" (3) to "Never" (0). Table 3 contains the average response in each cell, with retranslated equivalents ("Almost always", 2.5-3.0; "Often", 1.5-2.5; "Sometimes", 0.5-1.5).

Table 3

VR Services

VR Service	Provided directly	Purchased	Similar benefit	Total
Counseling & Guidance	2.72 Almost always	1.13 Sometimes	1.36 Sometimes	1.99 Often
Assessment	2.14 Often	1.92 Often	1.72 Often	1.93 Often
Adjustment counseling	2.09 Often	1.28 Sometimes	1.40 Sometimes	1.64 Often
Job referral	2.03 Often	1.32 Sometimes	1.29 Sometimes	1.63 Often
Job placement	1.70 Often	1.39 Sometimes	1.24 Sometimes	1.48 Sometimes
Transportation	1.49 Sometimes	1.32 Sometimes	1.30 Sometimes	1.48 Sometimes
Restoration	0.87 Sometimes	1.23 Sometimes	1.77 Often	1.34 Sometimes
Business/Vocational training	0.82 Sometimes	1.43 Sometimes	1.46 Sometimes	1.30 Sometimes
College/University	0.64 Sometimes	1.36 Sometimes	1.48 Sometimes	1.24 Sometimes
On-the-job training	1.02 Sometimes	1.26 Sometimes	1.40 Sometimes	1.23 Sometimes
Maintenance	1.34 Sometimes	0.86 Sometimes	1.38 Sometimes	1.20 Sometimes
Miscellaneous training	0.98 Sometimes	1.20 Sometimes	1.17 Sometimes	1.13 Sometimes
Independent Living	0.89 Sometimes	0.76 Sometimes	1.15 Sometimes	0.93 Sometimes

Training Background and Needs

Most (85%) of the respondents had training in alcohol or substance abuse counseling, but one third of these (38, 31% of the total) wanted more training. When asked if they would like more training to help them understand legal issues relating to the disability status under the Rehabilitation Act of 1973 as amended, for individuals who have problems with alcoholism/substance abuse, most (77%) said yes. Other training areas most often specified were training to help them (a) use supportive services in IWRP development to improve chances for successful rehabilitation (65%); (b) learn how to identify and counsel clients who have functional limitations affecting employment, with alcoholism/substance abuse as a secondary or "hidden" disability (64%); and (c) evaluate whether or not their applicant or client can benefit from treatment programs in their area (58%). The most popular media for information were (a) workshops (81%) and (b) videotapes (52%). Other media considered useful were newsletters (31%), manuals (28%), brochures (22%), and audiotapes (14%).

Treatment Modalities

Most of the counselors (101, 81%) thought that treatment modalities for American Indians and Alaska Natives who abuse alcohol and other substances sometimes needed to be different from treatment modalities for other clients. The most highly rated treatment models were, in descending order (Table 4); (a) Native American traditional healing, (b) 28-day Hazelden or Minnesota model inpatient treatment program, (c) A.A./N.A., (d) therapeutic community (long-range residential program), (e) Native American Church, and (f) spiritual or religious programs. These were all rated A (excellent) or B (good) by most of the respondents who had some knowledge of these treatment modalities. However, the two most highly rated treatment modalities were much less well-known than AA/NA, which was rated by 94 counselors, compared with 65 who were able to rate 28-day Hazelden or Minnesota model inpatient treatment programs and 37 who were able to rate Native American traditional healing methods. The lowest rating was given to Methadone maintenance programs, which were rated fair to poor by 73% of the counselors who had had some experience with them.

Table 4.
Rating of Treatment Models

Treatment Model	Rating*				Total	Other**	Mean rating
	A	B	C	D			
Native American traditional healing	9	14	13	1	37	34	2.838
28-day Hazelden/Minnesota/AA	11	34	17	3	65	20	2.815
Outpatient: AA/NA	16	43	32	3	94	8	2.766
Residential therapy program	8	25	17	3	53	21	2.717
Native American Church	3	15	7	3	28	37	2.643
Spiritual or religious programs	7	17	19	3	46	23	2.609
Outpatient employee assistance program	4	20	14	5	43	30	2.535
Psychiatric/Psychological models	4	29	28	5	66	12	2.485
Behavioral approaches	6	8	16	4	34	33	2.471
Outpatient drug-free program	3	23	28	3	57	21	2.456
Outpatient: Methadone	2	9	15	14	40	31	1.975

* A = Excellent, B = Good, C = Fair, D = Poor
** Some mark other than a rating was written.

When asked to rate 11 elements of treatment for American Indians and Alaska Natives who had alcoholism or substance abuse disabilities, all received more excellent and good ratings than fair or poor ratings. The highest ratings were, in descending order (Table 5); (a) encouragement to become responsible for one's own life, (b) individual sessions, (c) establishing new informal support networks, (d) group sessions, (e) support to deal directly with troublesome relationships, and (f) suggestions to healthier choices open to the client.

Table 5.
Elements of Treatment

Elements of Treatment	Rating*				Total	Other**	Mean rating
	A	B	C	D			
Encouraging responsibility	31	47	14	6	98	14	3.051
Individual sessions	25	48	21	2	96	18	3.000
New support networks	24	35	25	6	90	22	2.856
Group sessions	19	46	17	9	91	21	2.824
Support regarding relationships	21	38	32	3	94	19	2.819
Suggesting healthier choices	20	45	27	6	98	15	2.806
Confrontation	16	47	24	7	94	19	2.766
Drug education	18	44	22	10	94	19	2.745
Family counseling	22	32	27	9	90	23	2.744
Encouragement regarding feelings	20	43	26	10	99	14	2.737
Promotion of abstinence	23	38	25	12	98	15	2.735

* A = Excellent, B = Good, C = Fair, D = Poor
** Some mark other than a rating was written.

Most counselors (85, 69%) indicated that there was a program within a 100 mile radius of their office that was specifically designed to serve the needs of American Indians and Alaska Natives who have alcoholism or substance abuse as a disability, but less than half (44%) were satisfied with alcohol and substance abuse programs in their area. Nevertheless, when asked if they knew of a "good" treatment program for these clients, the names and addresses of about 50 treatment programs were offered, although few were mentioned by more than one respondent. The treatment programs recommended by more than one respondent are listed in appendix C.

Aftercare

When asked what aftercare programs were most important in helping a client maintain sobriety and/or abstinence, the most common answer was AA (n = 34), which received a "good" rating (mean = 2.77, max = 4.00). However, there was a wide variety of responses to this open-ended question.

Discussion

This survey supports the findings of Guyette (1982) that a majority of the treatment population preferred a combination of Native American healing practices and Western treatment strategies. That is, although there was widespread support for the AA model, the highest-rated (but less well-known) treatment model was Native American traditional healing (Table 4). In addition, most counselors thought that treatment modalities for American Indians/Alaska Natives who had alcoholism and other substance abuse problems sometimes needs to be different from treatment modalities for other clients. This is similar to Duran's approach (1990) and to Weibel-Orlando's (1989) "Syncretic Model," in which

> Indian values and ceremonial curing practices are incorporated into standard alcoholism intervention strategies. Western treatment programs such as Alcoholics Anonymous are stressed although certain structural or substantive changes maybe made so as to make the meetings "more Indian." Non-Indian treatment strategies are employed in conjunction with traditional Indian spiritual guests, curing rituals, and reidentification with one's tribal origins and beliefs.

Training

The survey also revealed that almost one out of every three counselors wanted more training. The preferred vehicle for training was workshops. The areas of training in which there was the most interest were, in order of descending importance:

(1) Legal issues relating to the disability status of American Indian/Alaska Natives who have problems with alcoholism/substance abuse, under the Rehabilitation Act of 1973 as amended (77%)

(2) use of supportive services in IWRP development to improve chances for successful rehabilitation (65%)

(3) learn how to identify and counsel clients who have functional limitations affecting employment, with alcoholism/substance abuse as a secondary or "hidden" disability (64%)

(4) evaluate whether or not their applicant or client can benefit from treatment programs in their area (58%)

VR Services

Results summarized in Table 3 suggest that American Indians/Alaska Natives with alcoholism/substance abuse disabilities may not be receiving all of the support services they need. For example, Maintenance services tend to be provided only "sometimes," whereas their chances of rehabilitation might be substantially better if these services were provided "often." On–the–job training also seems underutilized. In addition, some funding options seem under-utilized. For example, why are College/university training and Business/Vocational training "provided directly" so rarely (Table 3, 0.64 and 0.82 respectively)?

Recommendations

• *Design other training workshops in areas of interest described above.* Some of these could be videotaped for further distribution, since a majority of respondents indicated some interest in this training medium. In addition to the four areas of training identified in the preceding section, the following might be offered:

(1) Effective utilization of maintenance and on-the-job training services for the VR of American Indians/Alaska Natives with alcoholism/substance abuse

(2) Why it makes good sense to provide directly college and university training and business and vocational training to American Indians/Alaska Natives recovering from alcoholism/substance abuse

• *Identify and publish information about exemplary treatment programs of the "Syncretic" type.* This type of treatment program was identified in an earlier study of urban treatment programs as the type preferred by urban clients (Guyette, 1982). It also fits the profile of treatment programs that the respondents in the present survey rank most highly.

• *Alternatives to the requirement for three months' abstinence before implementing VR services are needed.* Too often this requirement serves to screen out applicants who want help. Legal issues can be a factor here, but as long as the applicant is *in recovery,* he or she can receive services. No 90-day waiting period is required. Counselors may need guidance on how to deal with this issue. When embarking on abstinence, an applicant needs support and reinforcement. Support in the form of career counseling, family healing therapy, etc., can help

motivate the client to maintain abstinence and to prepare him or her for success with other VR services.

• *VR counselors with expertise should be given specialty caseload responsibilities.* That is, counselors with special training, knowledge, and interest in substance abuse and a knowledge of how to work with American Indian/Alaska Native clients should be encouraged to specialize in working with American Indians/Alaska Natives with alcoholism/substance abuse. The underlying cultural, psychological, social, and economic factors are so immense that special expertise is usually needed for dealing with these clients.

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Appendix A

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Appendix B

Sample Cover Letter to Respondents

INSTITUTE FOR HUMAN DEVELOPMENT
ARIZONA UNIVERISTY AFFILIATED PROGRAM

9 June 1993

(Name
Address)

Dear VR Counselor,

The American Indian Rehabilitation Research and Training Center is conducting a survey of Vocational Rehabilitation counselors whose caseload includes a significant number of American Indians who have alcohol or substance abuse disorders. For the purposes of this study, "a significant number" means more than a few, but not necessarily a majority of your caseload. We have consulted with (program manager), who has agreed to help us contact you.

The purpose of this survey is to determine your perceptions about the magnitude of alcoholism and substance abuse in your American Indian client population, how seriously you think it affects their rehabilitation outcome, and what you think VR can or should do (within the limits of current legislative mandates). This survey is national in scope, but focuses mainly on areas where American Indian populations are concentrated. It ask you about what your needs are, with respect to training and other resources for helping your clients deal with this problem, and what your experience has been with various treatment programs for your clients. We will be happy to send a free copy of our report to you, if you are interested.

The purpose of this letter is to seek your cooperation in implementing this survey. Please fill out the enclosed questionnaire and return it to us as soon as possible.

Sincerely,

Robert M. Schacht
Co-Director of Research

Lee Gaseoma
Graduate Assistant

Appendix C

Recommended Programs

Recommended Treatment Centers

The following treatment centers were recommended by more than one VR counselor in the survey:

Mr. Leo Whiteford, Program Manager
Puyallup
Tribal Treatment Center
2209 E 32nd Street
Tacoma, WA 98948
(206) 593-0291

Mr. Hilton Queton, Executive Director
American Indian Center
818 East Davis
Grand Prairie, TX 75050
(214) 262-1349

Wilton Cuevas, Director
Alcohol Treatment Center
Indian Health Care Resource Center
1524 South Denver
Tulsa, OK 74119-3829
(918) 592-0695

Mr. Terry Beartusk, Executive Director
Thunder Child Treatment Center
Bldg, 24, VAMC
Sheridan, WY 82801
(307) 672-3484/3485

Mr. Kerry Gauthier, Director
Mash-Ka-Wisen
MN Indian Residential Treatment Center
PO Box 66
Sawyer, MN 55780
(218) 879-6731

Mr. Charles Bear-Comes-Out, Director
Northern Cheyenne Recovery Center
PO Box 857
Lame Deer, MT 59043
(406) 477-6381

Ron Sully, Program Director
Yankton Sioux Recovery Center
PO Box 517
Lake Andes, SD 57356
(605) 487-7841

Other treatment centers recommended by VR counselors in the survey:

Alaska
Ms. Pat Oskolkoss, Director
Ninilchik Community Clinic
PO Box 638
Ninilchik, AK 99639
(907) 567-3370

Arizona
Ms. Joanne Studges, Acting Exec. Director
Native Americans for Community Action
2717 N Steves Blvd., Suite 11
Flagstaff, AZ 86004
(602) 526-2968

Ms. Mona Polacca, Acting Asst. Director
Gila River Indian Community
Alcohol and Drug Abuse Program
PO Box 7
Sacaton, AZ 85247
(602) 562-3356

Ms. Nancy Stehle, Program Director
Winslow Counseling Center
211 E Third
Winslow, AZ 86047
(602) 289-4658

California
Mr. William Brown, Director
Fort Mojave Tribal Counseling Services
400 Merriman
Needles, CA 92363
(619) 326-3529

Ms. Roselyn Pace, Director
Santa Ynez Indian Health Clinic
PO Box 539
Santa Ynez, CA 93460
(805) 688-7070

Minnesota
Dorothy Sam, Director
Four Winds Lodge
Brainerd Reg. Human Services Center
1777 Highway 18 East
Brainerd, MN 56401
(218) 828-2546

Mississippi
Mr. James Wallace, CEO
Mississippi Band of Choctaw Indians
Choctaw Health Center
Route 7 - R50
Philadelphia, MS 39350

Montana
Mr. Pat Calf Looking, Director
Blackfeet Chemical Dependency Program
PO Box 1785
Browning, MT 59417
(406) 338-6330, ext. 314

Ms. Karen Brown, Director
Spotted Bull Treatment Center
PO Box 1027
Poplar, MT 59225
(406) 768-3852

Mr. Gilbert Scott, Director
Crow Agency Indian Health Service
Alcohol/Substance Abuse Program
PO Box 9
Crow Agency, MT 59022
(406) 638-2626

New Mexico
Ms. Enid Osborne, Program Director
Pueblo of San Felipe
PO Box A
San Felipe Pueblo, NM 87001
(505) 867-2311